EMPLOYER RESPONSE—DISCHARGE

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE.

Claimant Name:	SSN:
OROFINO LOCAL OFFICE IDAHO DEPT OF COMMERCE AND LABOR PO BOX 391 OROFINO ID 83544-0391 208-476-3471 (FAX)	Employer: Employer's Name, Address, Phone & Fax

Paid or to be paid:

Gross earnings for the past 12 months $	Severance: $	On (date):
Vacation: $	Bonus: $	On (date):
Date vacation payment will be received:	Holiday: $	On (date):

Supervisor's name:	Phone#:

Start date of employment:	Last day worked:	Date terminated:

1. What happened on the last day of work to cause the discharge i.e. the final incident or last straw?

2. If nothing happened on that day to cause the discharge, what was the final incident (last straw) that caused the discharge?

3. Why did you discharge the claimant?

4. What day did this incident occur

5. Please supply information regarding any previous incidents that are related to the claimant's discharge. (Please document date and description of incident (s).

6. How did the claimant's action adversely affect your business?

7. Was a company policy/established procedure violated? ☐ Yes ☐ No
If yes, how was the claimant made aware of the policy/procedure?
(PLEASE ATTACH COPY OF POLICY)

8. What was the expected job behavior & what should the claimant have done?

9. Warnings (verbal & written) the claimant received and the date they were received.
***Please provide copies of any written warnings**
***If verbal, please provide date, name & title of person who issued warning, and what was communicated to the claimant.**

10. Did you ever tell the claimant he/she could be discharged if the behavior continued? ☐ Yes ☐ No
If yes, please explain:

11. If warned, how did the claimant's behavior change

12. Additional information:

Employer/Employer's Representative Signature: _____

Print Name: _____ Title: _____

Phone Number: _____ Date: _____